Washington State
DEPARTMENT OF
SOCIAL & HEALTH
SERVICES

Medical Assistance Administration

Physical Therapy Program

Billing Instructions

(WAC 388-545-500)

May 2000

Copyright Disclosure

About this publication

This publication supersedes all previous billing instructions for Physical Therapy Services. Related programs have their own billing instructions. Services and/or equipment related to any of the programs listed below must be billed using their specific billing instructions:

- Home Health Services
- School Medical Services
- Neurodevelopmental Centers
- Outpatient Hospital
- Acute PM&R

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Washington State Department of Social and Health Services
May 2000

Received too many billing instructions?
Too few?
Address incorrect?

Please detach, fill out, and return the card located inside the back cover of this billing instruction. The information you provide will be used to update our records and provider information.

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Important Contacts

A provider may contact MAA with questions regarding its programs. However, MAA's response is based solely on the information provided to MAA's representative at the time of inquiry, and in no way exempts a provider from following the laws and rules that govern MAA's programs.

Applying for a provider

Call:
(800) 562-6188 and
Select Option #1

or call one of the following numbers:

(360) 725-1033
(360) 725-1026
(360) 725-1032

Where do I send my claims?

Hard Copy Claims:
Division of Program Support
PO Box 9247
Olympia WA 98507-9247

Magnetic Tapes/Floppy Disks:
Division of Program Support
Claims Control
PO Box 45560
Olympia, WA 98504-5560

How do I obtain copies of billing instructions or numbered memoranda?

Check out our web site at:
http://maa.dshs.wa.gov

Or write/call:
Provider Relations Unit
PO Box 45562
Olympia WA 98504-5562
(800) 562-6188

Where do I call if I have questions regarding…

Payments, denials, general questions regarding claims processing, or Healthy Options?

Provider Relations Unit
(800) 562-6188

Private insurance or third party liability, other than Healthy Options?

Coordination of Benefits Section
(800) 562-6136

Pharmacy Authorization?

(800) 848-2842

Electronic Billing?

Write/call:
Electronic Billing Unit
PO Box 45511
Olympia, WA 98504-5511
(360) 725-1267

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Definitions

This section defines terms and acronyms used throughout these billing instructions.

Bundled or Bundled Service(s) - Interventions which are incidental to the major procedure and are not separately reimbursable.

By Report (BR) - When a service, supply, or piece of equipment is new (its use is not yet standardized), or it is a variation on a standard practice, or if it is rarely provided, or it has no maximum allowance established, it may be paid *By Report*. The appropriateness and value of any service or item classified as By Report is evaluated on a case-by-case basis.

Client - An applicant for, or recipient of, DSHS medical care programs.

Department - The state Department of Social and Health Services (DSHS). (WAC 388-500-0005)

Explanation of Benefits (EOB) – A coded message on the Medical Assistance Remittance and Status Report that gives detailed information about the claim associated with that report.

Explanation of Medical Benefits (EOMB) – A federal report generated by Medicare for its providers that displays transaction information regarding Medicare claims processing and payments.

Health Maintenance Organization (HMO) – An entity licensed by the office of the insurance commissioner to provide comprehensive medical services directly to an eligible enrolled client in exchange for a premium paid by the department on a prepaid capitation risk basis. (WAC 388-500-0005)

Health Care Financing Administration Claim Form (HCFA-1500) - A claim form used to bill for Medicaid services.

Managed Care – A prepaid comprehensive system of medical and health care delivery including preventive, primary, specialty, and ancillary health services. (WAC 388-538-050)

Maximum Allowable - The maximum dollar amount that a provider may be reimbursed by MAA for specific services, supplies, or equipment.

Medicaid - The federal aid Title XIX program under which medical care is provided to persons eligible for the:

- Categorically needy program as defined in WAC 388-503-0310 and 388-511-1105; or
- Medically needy program as defined in WAC 388-503-0320. (WAC 388-500-0005)

Medical Assistance Administration (MAA) - The administration within the Department of Social and Health Services authorized by the secretary to administer the acute care portion of the Title XIX Medicaid and the state-funded medical care programs, with the exception of certain non-medical services for persons with chronic disabilities.

Medical Assistance IDentification (MAID) cards – MAID cards are the forms the Department of Social and Health Services uses to identify clients of medical programs. These cards are also known as DSHS Medical ID cards and were previously known as DSHS medical coupons. Clients receive a MAID card in the mail each month they are eligible.

Medically Necessary - A term for describing requested service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent the worsening of conditions that endanger life, or cause suffering or pain, or result in illness or infirmity, or threaten to cause or aggravate a handicap, or cause physical deformity or malfunction, and there is no other equally effective, more conservative, or substantially less costly course of treatment available or suitable for the client requesting the service. For the purpose of this section, 'course of treatment' may include mere observation or, where appropriate, no treatment at all. (WAC 388-500-0005)

Primary Care Case Manager (PCCM) – A physician, physician assistant (PA),or advanced registered nurse practitioner (ARNP) who provides, manages, and coordinates medical care for an enrollee. The PCCM is reimbursed fee-for-service for medical services provided to clients as well as a small, monthly, management fee.

Program Support, Division of (DPS) - The division within the Medical Assistance Administration which processes claims for payment under the Title XIX (federal) program and state-funded programs.

Program Unit – For CPT codes that are timed, each 15 minutes equals one unit. If the description does not include time, the procedure equals on unit, regardless of how long the procedure takes.

Program Visits – Visits based on CPT™ code description. Visits may or may not include time.

Provider or Provider of Service - An institution, agency, or person:

- Who has a signed agreement [Core Provider] with the department to furnish medical care, goods, and/or services to clients; and
- Is eligible to receive payment from the department. (WAC 388-500-0005)

Provider Number - A seven-digit identification number issued to service providers who have signed the appropriate contract(s) with the Medical Assistance Administration.

Remittance and Status Report - A report produced by the Medicaid Management Information System (MMIS) that provides detailed information concerning submitted claims and other financial transactions.

Revised Code of Washington (RCW) - Washington State laws.

Third Party - Any individual, entity or program that is or may be liable to pay all or part of the expenditures for medical assistance furnished under a State plan. (42 CFR 433.136)

Usual and Customary Fee - The rate that may be billed to the department for a certain service or equipment. This rate may not exceed:

- The usual and customary charge that you bill the general public for the same services; or
- If the general public is not served, the rate normally offered to other contractors for the same services.

Washington Administrative Code (WAC) - Codified rules of the State of Washington.

Physical Therapy

Who is eligible to provide physical therapy? [WAC 388-545-500(1)]

The following providers are eligible to provide physical therapy services:

- A licensed physical therapist or physiatrist; or
- A physical therapist assistant supervised by a licensed physical therapist.

Where must physical therapy services be provided? [WAC 388-545-500(3)(a-f)]

Physical therapy services that Medical Assistance Administration (MAA) eligible clients receive must be provided as part of an outpatient treatment program:

- In an office, home, or outpatient hospital setting;
- By a home health agency as described in Chapter 388-551 WAC;
- As part of the acute physical medicine and rehabilitation (Acute PM&R) program as described in Acute PM&R subchapter 388-550 WAC;
- By a neurodevelopmental center;
- By a school district or educational service district as part of an individual education or individualized family service plan as described in WAC 388-537-0100; or
- In accordance with the requirements of the Individuals with Disabilities Education Act (IDEA), for early intervention services for disabled children age two and younger.

Referral and Documentation Process

Adults (Age 21 and older) [Refer to WAC 388-545-500(5)]

Providers must document in a client's medical file that physical therapy services provided to clients age twenty-one and older are medically necessary. Such documentation may include justification that physical therapy services:

- Prevent the need for hospitalization or nursing home care;
- Assist a client in becoming employable;
- Assist a client who suffers from severe motor disabilities to obtain a greater degree of self-care or independence; or
- Are a part of a treatment program intended to restore normal function of a body part following injury, surgery, or prolonged immobilization.

Children (Age 20 and younger) (Refer to WAC 388-86-027)

The EPSDT/Healthy Kids screening provider must:

- Determine if there is a medical need for physical therapy; and
- Document the medical need and the referral in the child's physical therapy file.

The physical therapist must:

- Keep referral information on file in the form of a prescription, notes from telephone calls, etc.;
- Contact the referring EPSDT/Healthy Kids screening provider for information concerning the need for physical therapy services; and
- Keep the referring and/or continuing care provider apprised of the assessment, prognosis, and progress of the child(ren) the provider has referred to them for services.

Notifying Clients of Their Right to Make Their Own Health Care Decisions

All Medicare-Medicaid certified hospitals, nursing facilities, home health agencies, personal care service agencies, hospices, and managed health care organizations are federally mandated to give **all adult clients** written information about their rights, under state law, to make their own health care decisions.

Clients have the right to:

- Accept or refuse medical treatment;
- Make decisions concerning their own medical care; and
- Formulate an advance directive, such as a living will or durable power of attorney, for their health care.

Client Eligibility

Who is eligible? [Refer to WAC 388-545-500(2)]

Clients presenting Medical Assistance IDentification (MAID) cards with the following identifiers are eligible to receive Physical Therapy services:

- **CNP** (Categorically Needy Program)
- **CNP-Children's Health** (Categorically Needy Program-Children's Health)
- **Detox Only**
- **Emergency Hospital And Ambulance Only** (Medically Indigent Program)
  - ✓ Hospital Setting Only
- **GA-U No Out of State Care** (General Assistance-Unemployable)
- **LCP-MNP** (Limited Casualty Program-Medically Needy Program)
  Only when clients are:
  - ✓ Twenty years of age or younger and referred by a screening provider under the EPSDT/Healthy Kids program; or
  - ✓ Receiving home health care services.

Who is not eligible?

Clients presenting MAID cards with the following identifiers are not eligible for services under the Physical Therapy Program:

- **Family Planning Only** (Limited Coverage)
- **QMB Medicare Only**

Are clients enrolled in managed care eligible?

(Refer to WAC 388-538-060 and 095)

YES! Clients with an identifier in the HMO column on their MAID card are enrolled in one of MAA's Healthy Options managed care plans. All physical therapy services must be requested directly through the client's Primary Care Provider (PCP). Clients can contact their plan by calling the telephone number located on their MAID card.

To prevent billing denials, please check the client's MAID card prior to scheduling services and at the time of service to make sure proper authorization or referral is obtained from the PCP and/or plan.

Primary Care Case Management (PCCM) clients will have the identifier PCCM in the HMO column on their MAID cards. Please make sure these clients have been referred by their PCCM prior to receiving services. The referral number is required in field 17A on the HCFA-1500 claim form. (See *Billing* for further information.)

Coverage

MAA pays only for covered physical therapy services listed in this section when they are:

- Within the scope of an eligible client's medical care program;
- Medically necessary and ordered by a physician, PA, or an ARNP;
- Begun within 30 days of the date ordered;
- For conditions which are the result of injuries and/or medically recognized diseases and defects; and
- Within accepted physical therapy standards. [WAC 388-545-500(4)]

What is covered? [Refer to WAC 388-545-500(7-8)]

☞ **Note:** A program unit is based on the CPT code description. For CPT codes that are timed, each 15 minutes equals one unit. If the description does not include time, the procedure equals one unit regardless of how long the procedure takes.

- MAA does not limit coverage of physical therapy services if the client is 20 years of age or younger.
- MAA covers, without requiring prior authorization, the following ordered physical therapy services per client, per diagnosis, per calendar year, for clients 21 years of age and older:
  - ✓ One physical therapy evaluation. The evaluation is in addition to the 48 program units allowed per year;
  - ✓ 48 physical therapy program units; and
  - ✓ 96 additional outpatient physical therapy program units for the diagnoses listed on the following page.
- MAA pays for one visit to instruct in the application of transcutaneous electrical neurostimulator (TENS) per client, per lifetime.
- MAA covers two DME needs assessments per calendar year. Two physical therapy program units are allowed per assessment.
- MAA covers one wheelchair needs assessment in addition to the DME needs assessment per calendar year. Four physical therapy program units are allowed per assessment.

Additional Coverage (Client 21 years of age and older)

MAA covers a maximum of 96 physical therapy program units in addition to the original 48 units only when billed with one of the following diagnoses:

- **Principal** diagnosis codes:

Diagnosis Codes	Condition
315.3-315.9, 317-319	For medically necessary conditions for developmentally delayed clients
343 - 343.9	Cerebral palsy
741.9	Meningomyelocele
758.0	Down's syndrome
781.2-781.3	Symptoms involving nervous and musculoskeletal systems, lack of coordination
800-829.1	Surgeries involving extremities-Fractures
851-854.1	Intracranial injuries
880-887.7	Surgeries involving extremities-Open wounds with tendon involvement
941-949.5	Burns
950-957.9, 959-959.9	Traumatic injuries

-OR-

- A completed/approved inpatient Acute Physical Medicine & Rehabilitation (Acute PM&R) when the client no longer needs nursing services but continues to require specialized outpatient therapy for:

854	Traumatic Brain Injury (TBI)
900.82, 344.0, 344.1	Spinal Cord Injury, (Paraplegia & Quadriplegia)
436	Recent or recurrent stroke
340	Restoration of the levels of function due to secondary illness or loss for, Multiple Sclerosis (MS)
335.20	Amyotrophic Lateral Sclerosis (ALS)
343 - 343.9	Cerebral Palsy (CP)
357.0	Acute infective polyneuritis (Guillain-Barre syndrome)
941.4, 941.5, 942.4, 942.5, 943.4, 943.5, 944.4, 944.5, 945.4, 945.5, 946.4, 946.5	Extensive Severe Burns
707.0 & 344.0	Skin Flaps for Sacral Decubitus for Quads only
890-897.7, 887.6-887.7	Open wound of lower limb, Bilateral Limb Loss

Physical Therapy Program Limitations

Duplicate services for Occupational, Physical, and Speech therapy are not allowed for the same client when both providers are performing the same or similar procedure(s). [WAC 388-545-500 (11)]

Note: A program unit is based on the CPT code description. For CPT codes that are timed, each 15 minutes equals one unit. If the description does not include time, the procedure equals one unit regardless of how long the procedure takes.

If time is included in the CPT code description, the beginning and end times of each therapy modality must be documented in the client's medical record.

The following are considered part of the physical therapy program 48-unit limitation:

- Application of a modality to one or more areas not requiring direct patient contact (CPT codes 97010-97028);
- Application of a modality to one or more areas requiring direct patient contact (CPT codes 97032-97039);
- Therapeutic exercises (CPT codes 97110-97139);
- Manual therapy (CPT code 97140);
- Therapeutic procedures (CPT code 97150);
- Prosthetic training (CPT code 97520);
- Therapeutic activities (CPT code 97530)
- Self care/home management training (CPT code 97535);
- Community/work reintegration training (CPT code 97537); and
- Physical performance test or measurement (CPT code 97750). Do not use this code to bill for an evaluation (CPT code 97001) or re-evaluation (CPT code 97002).
- Assistive technology assessment (CPT code 97755)

The following are not included in the physical therapy program 48-unit limitation [Refer to WAC 388-545-500 (8)]:

- Orthotics fitting and training upper and/or lower extremities (CPT code 97504). Two units are allowed per day. This procedure can be billed alone or with other physical therapy CPT codes.

- Checkout for orthotic/prosthetic use (CPT code 97703). Two units are allowed per day. This procedure can be billed alone or with other physical therapy CPT codes.

- Muscle testing (CPT codes 95831-95834). One muscle testing procedure is allowed per day. Muscle testing procedures cannot be billed in combination with each other. These procedures can be billed alone or with other physical therapy CPT codes.

- Evaluation of physical therapy (CPT code 97001). Allowed once per calendar year, per client. Use CPT code 97001 to report the initial evaluation before the plan of care is established by the physical therapist or the physician. This is to evaluate the client's condition and establishing the plan of care.

- Re-evaluation of physical therapy (CPT code 97002). Allowed once per calendar year, per client. CPT code 97002 is for reporting the re-evaluation of a client who has been under a plan of care established by a physician or physical therapist. This evaluation is for reevaluating the client's condition and revising the plan of care under which the client is being treated.

- Wheelchair needs assessments (CPT code 97703). One allowed per calendar year. Four physical therapy program units are allowed per assessment. Indicate on the claim that this is a wheelchair needs assessment.

- DME needs assessments (CPT code 97703). Two allowed per calendar year. Two physical therapy program units are allowed per assessment. Indicate on the claim that this is a DME needs assessment.

- MAA reimburses Physical Therapists for active wound care management involving selective and non-selective debridement techniques to promote healing using CPT codes 97601 and 97602. The following conditions apply:

  - ✓ MAA allows one unit of CPT code 97601 or 97602 per client, per day. Providers may not bill CPT codes 97601 and 97602 in conjunction with one another.

  - ✓ Providers must not bill procedure codes 97601 and 97602 in addition to CPT codes 11040-11044.

- Custom splints (cockup and/or dynamic) (State-unique procedure code 0002M).

How do I request approval to exceed the limits?

For clients 21 years of age and older who need physical therapy beyond that which is allowed by diagnosis, the provider must request MAA approval to exceed the limits.

Limitation extensions (LEs) and expedited prior authorization (EPA) numbers do not override the client's eligibility or program limitations. Not all eligibility groups receive all services. For example: therapies are not covered under the medically indigent (MI) program.

Limitation Extensions

Limitation Extensions are cases where a provider can verify that it is medically necessary to provide more units of service than allowed in MAA's billing instruction and Washington Administrative Code (WAC). Providers must use the EPA process to create their own EPA numbers. These EPA numbers are subject to post payment review.

In cases where the EPA cannot be met and the provider feels that additional services are medically necessary, the provider must request MAA approval for limitation extension. The request must state the following in writing:

1. The name and Patient Identification Code (PIC) of the client;
2. The therapist's name, provider number, and fax number;
3. The prescription for therapy from the provider. A letter describing the client's condition and the need for therapy is helpful;
4. The number of units and procedure codes used during calendar year;
5. The number of additional units and procedure codes needed;
6. The most recent therapy progress notes;
7. Copy of the physical therapy evaluation;
8. If therapy is related to an injury or illness, the date(s) of injury or onset of illness;
9. If surgery has been done, date(s) of surgery;
10. The primary diagnosis or ICD-9-CM diagnosis code; and
11. The reason why the client needs more therapy and why he or she is not independent in a home exercise program.

Send your request to:

MAA – Division of Medical Management
Attn: Medical Request Coordinator
PO Box 45506
Olympia, WA 98504-5506
Fax: (360) 586-2262

Expedited Prior Authorization (EPA)

The EPA process is designed to eliminate the need for written authorization. The intent is to establish authorization criteria and identify these criteria with specific codes, enabling providers to create an "EPA" number when appropriate.

To bill MAA for diagnoses, procedures and services that meet the EPA criteria on the following pages, the provider must **create a 9-digit EPA number**. The first six digits of the EPA number must be **870000**. The last 3 digits must be the code number of the diagnostic condition, procedure, or service that meets the EPA criteria. Enter the EPA number on the billing form in the authorization number field, or in the *Authorization* or *Comments* field when billing electronically. With HIPAA implementation, multiple authorization (prior/expedited) numbers can be billed on a claim. If you are billing multiple EPA numbers, you must list the 9-digit EPA numbers in field 19 of the claim form exactly as follows (*not all required fields are represented in the example*):

19. Line 1: 870000725/ Line 2: 870000726

If you are only billing one EPA or PA number on a paper HCFA-1500 claim form, please continue to list the 9-digit EPA number in field 23 of the claim form.

Example: The 9-digit authorization number for additional physical therapy units for a client who has used 48 PT units this calendar year and subsequently has had knee surgery, would be **870000640** (**870000** = first six digits of all expedited prior authorization numbers, **640** = last three digits of an EPA number indicating the service and which criteria the case meets).

Expedited Prior Authorization Guidelines

A. Diagnoses

Only diagnostic information obtained from the hospital or outpatient chart may be used to meet conditions for EPA. Claims submitted without the appropriate diagnosis, procedure code or service as indicated by the last three digits of the EPA number will be denied.

B. Documentation

The billing provider must have documentation of how expedited criteria was met, and have this information in the client's file available to MAA on request.

Washington State
Expedited Prior Authorization Criteria Coding List
For Physical Therapy(PT) LEs

PHYSICAL THERAPY

CPT: 97010-97150, 97520-97537, 97750, 97755

Code	Criteria
640	**An additional 48 Physical Therapy program units** when the client has already used the allowed program units for the current year and has one of the following surgeries or injuries: 1. Lower Extremity Joint Surgery 2. CVA not requiring acute inpatient rehabilitation 3. Spine surgery
641	**An additional 96 Physical Therapy program units** when the client has already used the allowed program units for the current year and has recently completed an acute inpatient rehabilitation stay.

Are school medical services covered?

MAA covers physical therapy services provided in a school setting for school-contracted services that are noted in the client's Individual Education Program (IEP) or Individualized Family Service Plan (IFSP). Refer to MAA's School Medical Services Billing Instructions. (See *Important Contacts*.)

What is not covered? **[WAC 388-545-500(12)(13)]**

- MAA does not cover physical therapy services that are included as part of the reimbursement for other treatment programs. This includes, but is not limited to, hospital inpatient and nursing facility services.

- MAA does not cover physical therapy services performed by a physical therapist in an outpatient hospital setting when the physical therapist is not employed by the hospital. Reimbursement for services must be arranged through the hospital.

Fee Schedule

Note: A program unit is based on the CPT® code description. For CPT codes that are timed, each 15 minutes equals one unit. If the description does not include time, the procedure equals one unit regardless of how long the procedure takes.

Due to its licensing agreement with the American Medical Association, MAA publishes only official, brief CPT code descriptions. To view the full descriptions, please refer to your current CPT book.

Procedure Code	Brief Description	July 1, 2004 Maximum Allowable Fee	
		Non Facility Setting	Facility Setting
Tens Application			
64550	Apply neurostimulator	11.11	5.44
Muscle Testing (The maximum allowable is for payment in full, regardless of time required.)			
95831	Limb muscle testing, manual	14.28	9.52
95832	Muscle testing manual	12.47	9.52
95833	Body muscle testing, manual	21.08	16.10
95834	Body muscle testing, manual	25.39	20.40
95851	Range of motion measurements	12.24	5.67
95852	Range of motion measurements	8.61	3.85
Modalities			
97010	Hot or cold packs therapy	Bundled	
97012	Mechanical traction therapy	9.07	9.07
97014	Electrical stimulation therapy	8.61	8.61
97016	Vasopneumatic device therapy	8.61	8.61

Procedure Code	Brief Description	July 1, 2004 Maximum Allowable Fee	
		Non Facility Setting	Facility Setting
97018	Paraffin bath therapy	4.08	4.08
97020	Microwave therapy	2.95	2.95
97022	Whirlpool therapy	9.07	9.07
97024	Diathermy treatment	3.63	3.63
97026	Infrared therapy	2.95	2.95
97028	Ultraviolet therapy	3.63	3.63
(For the procedures listed below, the therapy provider is required to be in constant attendance.)			
97032	Electrical stimulation	9.52	9.52
97033	Electrical current therapy	12.70	12.70
97034	Contrast bath therapy	8.61	8.61
97035	Ultrasound therapy	7.48	7.48
97036	Hydrotherapy	14.06	14.06
97039	Physical therapy treatment	7.03	7.03
Therapeutic Procedures (Therapy provider is required to be in constant attendance.)			
97110	Therapeutic exercises	17.46	17.46
97112	Neuromuscular re-education	17.46	17.46
97113	Aquatic therapy/exercises	19.95	19.95
97116	Gait training therapy	14.96	14.96
97124	Massage therapy	13.38	13.38
97139	Physical medicine procedure	9.52	9.52
97140	Manual therapy	16.10	16.10
97150	Group therapeutic procedures	10.65	10.65

Procedure Code	Brief Description	July 1, 2004 Maximum Allowable Fee	
		Non Facility Setting	Facility Setting
97504	Orthotic training	18.59	18.59
97520	Prosthetic training	17.00	17.00
97530	Therapeutic activities	17.68	17.68
97535	Self care mngment training	18.14	18.14
97537	Community/work reintegration	16.55	16.55
97542	Wheelchair mngment training	Not Covered	
97545	Work hardening	Not Covered	
97546	Work hardening add-on	Not Covered	
97601	Wound care selective	23.58	23.58
97602	Wound care non-selective	19.50	19.50
Tests and Measurements			
97001	Pt evaluation	45.11	38.77
97002	Pt re-evaluation	23.80	19.50
97703	Prosthetic checkout	15.42	15.42
97005	Athletic evaluation	Not Covered	
97006	Athletic re-evaluation	Not Covered	
97750	Physical performance test	17.46	17.46
97755	Assistive technology assessment	21.08	21.08
Other Procedures			
97532	Cognitive skills development	Not Covered	
97533	Sensory integration	Not Covered	
97799	Unlisted physical medicine rehabilitation service or procedure	By Report	

Billing

What is the time limit for billing? [Refer to WAC 388-502-0150]

- MAA requires providers to submit an initial claim, be assigned an internal control number (ICN), and adjust all claims in a timely manner. MAA has two timeliness standards: 1) for initial claims; and 2) for resubmitted claims.

- The provider must submit claims as described in MAA's billing instructions.

- MAA requires providers to obtain an ICN for an initial claim within 365 days from any of the following:

  - ✓ The date the provider furnishes the service to the eligible client;
  - ✓ The date a final fair hearing decision is entered that impacts the particular claim;
  - ✓ The date a court orders MAA to cover the services; or
  - ✓ The date DSHS certifies a client eligible under delayed[1] certification criteria.

- MAA may grant exceptions to the 365 day time limit for initial claims when billing delays are caused by either of the following:

  - ✓ DSHS certification of a client for a retroactive[2] period; or
  - ✓ The provider proves to MAA's satisfaction that there are other extenuating circumstances.

- MAA requires providers to bill known third parties for services. See WAC 388-501-0200 for exceptions. Providers must meet the timely billing standards of the liable third parties, in addition to MAA's billing limits.

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[1] **Delayed Certification:** A person applies for a medical program prior to the month of service and a delay occurs in the processing of the application. Because of this delay, the eligibility determination date becomes later than the month of service. A delayed certification indicator will appear on the MAID card. The provider MUST refund any payment(s) received from the client for the period he/she is determined to be medical assistance-eligible, and then bill MAA for those services.

[2] **Retroactive Certification:** An applicant receives a service, then applies to MAA for medical assistance at a later date. Upon approval of the application, the person was found eligible for the medical service at the time he or she received the service. The provider MAY refund payment made by the client and then bill MAA for the service.

- Providers may resubmit, modify, or adjust any timely initial claim, except pharmacy claims, for a period of 36 months from the date of service. Pharmacy claims must be resubmitted, modified, or adjusted within 15 months from the date of service.

Note: MAA does not accept any claim for resubmission, modification, or adjustment after the allotted time period listed above.

- The allotted time periods do not apply to overpayments that the provider must refund to DSHS. After the allotted time periods, a provider may not refund overpayments to MAA by claim adjustment. The provider must refund overpayments to MAA by a negotiable financial instrument such as a bank check.

- The provider, or any agent of the provider, must not bill a client or a client's estate when:

  ✓ The provider fails to meet these listed requirements; and
  ✓ MAA does not pay the claim.

What fee should I bill MAA for eligible clients?

Bill MAA your usual and customary fee.

How do I bill for services provided to PCCM clients?

When billing for services provided to PCCM clients:

- Enter the referring physician or Primary Care Case Manager name in field 17 on the HCFA-1500 claim form; and

- Enter the seven-digit identification number of the Primary Care Case Managers (PCCM) who referred the client for the services(s). If the client is enrolled in a PCCM plan and the PCCM referral number is not in field 17a when you bill MAA, the claim will be denied.

Third-Party Liability

You must bill the insurance carrier(s) indicated on the client's Medical Assistance IDentification (MAID) card. An insurance carrier's billing time limit for claim submissions may vary. It is your responsibility to meet the insurance carrier's requirements relating to billing time limits, as well as MAA's, prior to any payment by MAA.

You must meet MAA's 365-day billing time limit even if you have not received notification of action from the insurance carrier. If your claim is denied due to any existing third-party liability, refer to the corresponding MAA Remittance and Status Report for insurance information appropriate for the date of service.

If you receive an insurance payment and the carrier pays you less than the maximum amount allowed by MAA, or if you have reason to believe that MAA may make an additional payment:

- Submit a completed claim form to MAA;
- Attach the insurance carrier's statement or EOB;
- If rebilling, also attach a copy of the MAA Remittance and Status Report showing the previous denial; or
- If you are rebilling electronically, list the Internal Control Number (ICN) of the previous denial in the comments field of the Electronic Media Claim (EMC).

Third-party carrier codes are available on the Internet at http://maa.dshs.wa.gov or by calling the Coordination of Benefits Section at 1-800-562-6136.

How do I bill for clients who are eligible for both Medicare and Medical Assistance?

If a client is eligible for both Medicare and Medical Assistance**, you must first submit a claim to Medicare within Medicare's time limitations.** MAA may make an additional payment after Medicare reimburses you.

- If Medicare pays the claim, the provider must bill MAA within six months of the date Medicare processes the claims.
- If Medicare denies payment of the claim, MAA requires the provider to meet MAA's initial 365-day requirement for initial claims.

Medicare Part A

Benefits under Medicare Part A cover the hospital portion of the eligible client's medical care. This includes inpatient/outpatient hospital care, inpatient care in a skilled nursing facility following a hospital stay, home health care, and hospice care.

Under Part A, Medicare will pay its allowed charges, minus any deductible and/or coinsurance, when appropriate. MAA pays for the deductible and coinsurance up to MAA's maximum allowable.

When billing Medicare:

- Indicate *Medical Assistance* and include the patient identification code (PIC) on the claim form as shown on the MAID card. Enter the Medical Assistance provider number.
- Accept assignment.
- If Medicare has allowed the service, in most cases Medicare will forward the claim to MAA. MAA then processes your claim for any supplemental payments for deductible and coinsurance.
- If Medicare does not forward your claim to MAA **within 30 days** from its statement date, send the UB-92 claims form and a copy of the Part A Explanation of Medical Benefits (EOMB) form to MAA for processing.
- When Part A services are totally disallowed by Medicare but are covered by MAA, bill MAA on the UB-92 claim form and attach copies of Medicare's EOMB with the denial reasons.

☞ **Please Note:**

- ✓ **Medicare/Medical Assistance billing claims must be received by MAA within six (6) months of the Medicare EOMB paid date.**
- ✓ **A Medicare Remittance Notice or EOMB must be attached to each claim.**

Medicare Part B

Benefits covered under Part B include: **Physician, outpatient hospital services, home health, durable medical equipment, and other medical services and supplies** not covered under Part A.

When the words *"This information is being sent to either a private insurer or Medicaid fiscal agent,"* appear on your Medicare remittance notice, it means that your claim has been forwarded to MAA or a private insurer for deductible and/or coinsurance processing.

If you have received a payment or denial from Medicare, but it does not appear on your MAA Remittance and Status Report (RA) within 45 days from Medicare's statement date, you should bill MAA directly.

- If Medicare has made payment, and there is no balance due from MAA, you must submit a HCFA-1500 claim form (without the "XO" indicator in field 19). Bill only those lines Medicare paid. Do no submit paid lines with denied lines. This could cause a delay in payment.

- If Medicare denies services, but MAA covers them, you must bill on a HCFA-1500 claim form (without the "XO" indicator in field 19). Bill only those lines Medicare denied. Do not submit denied lines with paid lines. This could cause a delay in payment.

- If Medicare denies a service that requires prior authorization by MAA, MAA will waive the prior authorization requirement but will still require authorization. Authorization or denial of your request will be based upon medical necessity.

☞ **Please Note:**

- ✓ **Medicare/Medical Assistance billing claims must be received by MAA within six (6) months of the Medicare EOMB paid date.**
- ✓ **A Medicare Remittance Notice or EOMB must be attached to each claim. Failure to do so will result in delay of your payment.**

Payment Methodology – Part B

- MMIS compares MAA's allowed amount to Medicare's allowed amount and selects the lesser of the two. (If there is no MAA allowed amount, we use Medicare's allowed amount.)
- Medicare's payment is deducted from the amount selected above.
- If there is *no* balance due, the claim is denied because Medicare's payment exceeds MAA's allowable.
- If there *is* a balance due, payment is made towards the deductible and/or coinsurance up to MAA's maximum allowable.

MAA cannot make direct payments to clients to cover the deductible and/or coinsurance amount of Part B Medicare. MAA *can* pay these costs to the provider on behalf of the client when:

1) The provider accepts assignment; and

2) The total combined reimbursement to the provider from Medicare and Medicaid does not exceed Medicare or Medicaid's allowed amount, whichever is less.

What records must be kept? [Refer to WAC 388-502-0020]

Enrolled providers must keep legible, accurate, and complete charts and records to justify the services provided to each client, including, but not limited to:

- Patient's name and date of birth;
- Name and title of person performing the service, if other than the billing practitioner;
- Chief complaint or reason for each visit;
- Pertinent medical history;
- Pertinent findings on examination;
- Medications, equipment, and/or supplies prescribed or provided;
- Description of treatment (when applicable);
- Recommendations for additional treatments, procedures, or consultations;
- X-rays, tests, and results;
- Plan of treatment and/or care, and outcome; and
- Specific claims and payments received for services.

Charts and records must be available to DSHS, its contractors and the US Department of Health and Human Services upon request.

How to Complete the HCFA-1500 Claim Form

The HCFA-1500 (U2) (12-90) (Health Insurance Claim Form) is a universal claim form used by many agencies nationwide; a number of the fields on the form do not apply when billing the Medical Assistance Administration (MAA). Some field titles may not reflect their usage for this claim type. The numbered boxes on the claim form are referred to as fields.

General Instructions

- Please use an original, red and white HCFA-1500 (U2) (12-90) claim form.
- Enter only one (1) procedure code per detail line (field 24A-24K). If you need to bill more than six (6) lines per claim, please complete an additional HCFA-1500 claim form.
- You must enter all information within the space allowed.
- Use upper case (capital letters) for all alpha characters.
- Do not write, print, or staple any attachments in the bar area at the top of the form.

1a. **Insured's I.D. No.:** Required. Enter the Medicaid Patient (client) Identification Code (PIC) - an alphanumeric code assigned to each Medical Assistance client - exactly as shown on the Medical Assistance IDentification (MAID) card. This information is obtained from the client's current monthly MAID card and consists of the client's:

- First and middle initials (a dash [-] *must* be used if the middle initial is not available).
- Six-digit birthdate, consisting of *numerals only* (MMDDYY).
- First five letters of the last name. If there are fewer than five letters in the last name, leave spaces for the remainder before adding the tiebreaker.
- An alpha or numeric character (tiebreaker).

For example:

- ✓ Mary C. Johnson's PIC looks like this: MC010667JOHNSB.
- ✓ John Lee's PIC needs two spaces to make up the last name, does not have a middle initial and looks like this: J-100257LEE B.
- ✓ A PIC for Mary C. Johnson's newborn baby would look like this: MC010667JOHNSB and would show a **B** indicator in *field 19*.

2. **Patient's Name:** Required. Enter the last name, first name, and middle initial of the Medicaid client (the receiver of the services for which you are billing).

3. **Patient's Birthdate:** Required. Enter the birthdate of the Medicaid client.

4. **Insured's Name (Last Name, First Name, Middle Initial):** When applicable. If the client has health insurance through employment or another source (e.g., private insurance, Federal Health Insurance Benefits, CHAMPUS, or CHAMPVA), list the name of the insured here. Enter the name of the insured except when the insured and the client are the same - then the word *Same* may be entered.

5. **Patient's Address:** Required. Enter the address of the Medicaid client who has received the services you are billing for (the person whose name is in *field 2*.)

9. **Other Insured's Name:** Secondary insurance. When applicable, enter the last name, first name, and middle initial of the insured. If the client has insurance secondary to the insurance listed in *field 11*, enter it here.

9a. Enter the other insured's policy or group number *and* his/her Social Security Number.

9b. Enter the other insured's date of birth.

9c. Enter the other insured's employer's name or school name.

9d. Enter the insurance plan name or the program name (e.g., the insured's health maintenance organization, private supplementary insurance).

Please note: DSHS, Welfare, Provider Services, Healthy Kids, First Steps, Medicare, etc., are inappropriate entries for this field.

10. **Is Patient's Condition Related to:** Required. Check *yes* or *no* to indicate whether employment, auto accident or other accident involvement applies to one or more of the services described in *field 24*. ***Indicate the name of the coverage source in field 10d*** (L&I, name of insurance company, etc.).

11. Insured's Policy Group or FECA (Federal Employees Compensation Act) Number: Primary insurance. When applicable. This information applies to the insured person listed in *field 4*. Enter the insured's policy and/or group number and his/her social security number. The data in this field will indicate that the client has other insurance coverage and Medicaid pays as payor of last resort.

11a. Insured's Date of Birth: Primary insurance. When applicable, enter the insured's birthdate, if different from *field 3*.

11b. **Employer's Name or School Name:** Primary insurance. When applicable, enter the insured's employer's name or school name.

11c. **Insurance Plan Name or Program Name:** Primary insurance. When applicable, show the insurance plan or program name to identify the primary insurance involved. *(Note: This may or may not be associated with a group plan.)*

11d. **Is There Another Health Benefit Plan?:** Required if the client has secondary insurance. Indicate *yes* or *no*. If yes, you should have completed *fields 9a.-d*. If the client has insurance, and even if you know the insurance will not cover the service you are billing, you must check *yes*. **If 11d. is left blank, the claim may be processed and denied in error.**

17. **Name of Referring Physician or Other Source:** When applicable, enter the referring physician or Primary Care Case Manager name. This field *must* be completed for consultations, or for referred laboratory or radiology services (or any other services indicated in your billing instructions as requiring a referral source).

17a. **I.D. Number of Referring Physician:** When applicable, 1) enter the seven-digit, MAA-assigned identification number of the provider who *referred or ordered* the medical service; OR 2) when the Primary Care Case Manager (PCCM) referred the service, enter his/her seven-digit identification number here. If the client is enrolled in a PCCM plan and the PCCM referral number is not in this field when you bill MAA, the claim will be denied.

The referring provider's Medical Assistance provider number or name and the statement "EPSDT referral" must be entered in the appropriate field.

19. **Reserved For Local Use:** When applicable, enter indicator B to indicate *Baby on Parent's PIC.* Enter "T" for school contracted services that are noted in the client's IEP or EFSP. Direct entry and electronic billers must use their appropriate field. **If you have more than one EPA number to bill, place both numbers here.**

21. **Diagnosis or Nature of Illness or Injury:** When applicable, enter the appropriate diagnosis code(s) in areas 1, 2, 3, and 4.

22. **Medicaid Resubmission:** When applicable. If this billing is being submitted beyond the 365-day billing time limit, enter the ICN that verifies that your claim was originally submitted within the time limit. (The ICN number is the claim number listed on the Remittance and Status Report.)

23. **Prior Authorization Number for Limitation Extensions:** When applicable. If the service or equipment you are billing for requires authorization, enter the nine-digit number assigned to you. Only one authorization number is allowed per claim.

24. **Enter only one (1) procedure code per detail line (fields 24A - 24K). If you need to bill more than six (6) lines per claim, please use an additional HCFA-1500 claim form.**

24A. **Date(s) of Service:** Required. Enter the "from" and "to" dates using all six digits for each date. Enter the month, day, and year of service numerically (e.g., October 4, 2003 = 100403). **Do not use slashes, dashes, or hyphens to separate month, day, or year (MMDDYY).**

24B. **Place of Service:** Required. These are the only appropriate code(s) for Washington State Medicaid:

Code Number	To Be Used For
11	Office
12	Client's residence
99	Other

24C. **Type of Service:** No longer required.

24D. **Procedures, Services or Supplies CPT/HCPCS:** Required. Enter the appropriate Current Procedural Terminology (CPT) or HCFA Common Procedure Coding System (HCPCS) procedure code for the services being billed.

24E. **Diagnosis Code:** Required. Enter the ICD-9-CM diagnosis code related to the procedure or service being billed (for each item listed in 24D). A diagnosis code is required for each service or line billed. Enter the code exactly as shown in ICD-9-CM.

24F. **$ Charges:** Required. Enter your usual and customary charge for the service performed. If more than one unit is being billed, the charge shown must be for the total of the units billed. Do not include dollar signs or decimals in this field. Do not add sales tax. Sales tax is automatically calculated by the system and included with your remittance amount.

24G. **Days or Units:** Required. Enter the total number of program units for each line. These figures must be whole units.

25. **Federal Tax I.D. Number:** Leave this field blank.

26. **Your Patient's Account No.:** Not required. Enter an alphanumeric ID number, i.e., a medical record number or patient account number. This number will be printed on your Remittance and Status Report under the heading *Patient Account Number*.

28. **Total Charge:** Required. Enter the sum of your charges. Do not use dollar signs or decimals in this field.

29. **Amount Paid:** If you receive an insurance payment or client-paid amount, show the amount here, and attach a copy of the insurance EOB. If payment is received from source(s) other than insurance, specify the source in *field 10d*. Do not put Medicare payment here or use dollar signs or decimals in this field.

30. **Balance Due:** Required. Enter balance due. Enter total charges minus any amount(s) in *field 29*. Do not use dollar signs or decimals in this field.

33. **Physician's, Supplier's Billing Name, Address, Zip Code and Telephone Number:** Required. Put the *Name, Address,* and *Telephone Number* on all claim forms.

Group: Required. Please enter your seven-digit provider number assigned to you by MAA.

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

SAMPLE

APPROVED OMB-0938-0008

PICA

HEALTH INSURANCE CLAIM FORM

PICA

CARRIER

1. MEDICARE ☐ (Medicare #) MEDICAID ☒ (Medicaid #) CHAMPUS ☐ (Sponsor's SSN) CHAMPVA ☐ (VA File #) GROUP HEALTH PLAN ☐ (SSN or ID) FECA BLK LUNG ☐ (SSN) OTHER ☐ (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): N-120346BOBO A

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): BOBO NATALIE

3. PATIENT'S BIRTH DATE MM DD YY: 12 03 46 SEX M ☐ F ☒

4. INSURED'S NAME (Last Name, First Name, Middle Initial):

5. PATIENT'S ADDRESS (No., Street): 500 CENTRAL

6. PATIENT RELATIONSHIP TO INSURED: Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street):

CITY: ANYTOWN STATE: WA

8. PATIENT STATUS: Single ☐ Married ☐ Other ☐

CITY: STATE:

ZIP CODE: 98000 TELEPHONE (Include Area Code): (360) 555-1199

Employed ☐ Full-Time Student ☐ Part-Time Student ☐

ZIP CODE: TELEPHONE (INCLUDE AREA CODE): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES ☐ NO ☒

a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. AUTO ACCIDENT? YES ☐ NO ☒ PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES ☐ NO ☒

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES ☐ NO ☒ ***If yes***, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

PATIENT AND INSURED INFORMATION

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: DR BROWN

17a. I.D. NUMBER OF REFERRING PHYSICIAN: 1234567

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES ☐ NO ☐ $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 343.9
2. ____.__
3. ____.__
4. ____.__

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 10	01	03	10	01	03	11		97001		343.9	4482	1				
2																
3																
4																
5																
6																

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER SSN ☐ EIN ☐

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES ☐ NO ☐

28. $ TOTAL CHARGE: 4482

29. $ AMOUNT PAID:

30. $ BALANCE DUE: 4482

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

PHYSICAL THERAPY USA
123 MAIN ST
ANYTOWN, WA 98000 360-555-4444

PIN# GRP# 7000001

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) ***PLEASE PRINT OR TYPE*** FORM HCFA-1500 (12-90), FORM RRB-1500, FORM OWCP-1500

Common Questions Regarding Medicare Part B/ Medicaid Crossover Claims

Q: Why do I have to mark "XO" in box 19 on crossover claim?

A: The "XO" allows our mailroom staff to identify crossover claims easily, ensuring accurate processing for payment.

Q: Where do I indicate the coinsurance and deductible?

A: You must enter the total combined coinsurance and deductible in field 24D on each detail line on the HCFA-1500 claim form.

Q: What fields do I use for HCFA-1500 Medicare information?

A:

In Field:	Please Enter:
19	an "XO"
24D	total combined coinsurance and deductible
24K	Medicare's allowed charges
29	Medicare's total deductible
30	Medicare's total payment
32	Medicare's EOMB process date, and the third-party liability amount

Q: When I bill Medicare-denied lines to MAA, why is the claim denied?

A: If your bill has an "XO" in field 19, it is not a crossover when Medicare denies your claim or if you are billing for Medicare-denied lines. The bill must be submitted without an "XO" and the Medicare EOMB must be attached to the claim.

Q: How do my claims reach Medicaid?

A: After Medicare has processed your claim, and if Medicare has allowed the services, in most cases Medicare will forward the claim to MAA for any supplemental Medicaid payment. When the remarks code is, *"MA07-The claim information has also been forwarded to Medicaid for review*," it means that your claim has been forwarded to MAA.

If **Medicare has paid** and the Medicare crossover claim does not appear on the MAA Remittance and Status Report within 30 days of the Medicare statement date, you should bill MAA on the HCFA-1500 claim form with an "XO" in box 19.

If **Medicare denies** a service, bill MAA using the HCFA-1500 claim form without an "XO" on the claim. Be sure to attach the Medicare denial letter or EOMB to your claim to avoid delayed or denied payment due to late submission.

REMEMBER! You must submit your claim to MAA within six months of the Medicare statement date if Medicare has paid or 365 days from date of service if Medicare has denied.

How to Complete the HCFA-1500 Claim Form for Medicare Part B/Medicaid Crossovers

The HCFA-1500 (U2) (12-90) (Health Insurance Claim Form) is a universal claim form used by many agencies nationwide; a number of the fields on the form do not apply when billing the Medical Assistance Administration (MAA). Some field titles may not reflect their usage for this claim type. The numbered boxes on the claim form are referred to as fields.

The HCFA-1500 claim form, used for Medicare/Medicaid Benefits Coordination, cannot be billed electronically.

General Instructions

- Please use an original, red and white HCFA-1500 (U2) (12-90) claim form.
- Enter only one (1) procedure code per detail line (field 24A-24K). If you need to bill more than six (6) lines per claim, please complete an additional HCFA-1500 claim form.
- You must enter all information within the space allowed.
- Use upper case (capital letters) for all alpha characters.
- Do not write, print, or staple any attachments in the bar area at the top of the form.

FIELD DESCRIPTION

1a. **Insured's I.D. No.:** Required. Enter the Medicaid Patient Identification Code (PIC) - an alphanumeric code assigned to each Medical Assistance client - exactly as shown on the Medical Assistance IDentification (MAID) card. This information is obtained from the client's current monthly MAID card and consists of the client's:

- First and middle initials (a dash [-] *must* be used if the middle initial is not available).
- Six-digit birthdate, consisting of *numerals only* (MMDDYY).
- First five letters of the last name. If there are fewer than five letters in the last name, leave spaces for the remainder before adding the tiebreaker.
- An alpha or numeric character (tiebreaker).

For example:

- ✓ Mary C. Johnson's PIC looks like this: MC010633JOHNSB.
- ✓ John Lee's PIC needs two spaces to make up the last name, does not have a middle initial and looks like this: J-100226LEE B.

2. **Patient's Name:** Required. Enter the last name, first name, and middle initial of the Medicaid client (the receiver of the services for which you are billing).

3. **Patient's Birthdate:** Required. Enter the birthdate of the Medicaid client.

4. **Insured's Name (Last Name, First Name, Middle Initial):** When applicable. If the client has health insurance through employment or another source (e.g., private insurance, Federal Health Insurance Benefits, CHAMPUS, or CHAMPVA), list the name of the insured here. Enter the name of the insured except when the insured and the client are the same - then the word *Same* may be entered.

5. **Patient's Address:** Required. Enter the address of the Medicaid client who has received the services you are billing for (the person whose name is in *field 2*).

9. **Other Insured's Name:** Secondary insurance. When applicable, enter the last name, first name, and middle initial of the insured. If the client has insurance secondary to the insurance listed in *field 11*, enter it here.

9a. Enter the other insured's policy or group number *and* his/her Social Security Number.

9b. Enter the other insured's date of birth.

9c. Enter the other insured's employer's name or school name.

9d. Enter the insurance plan name or the program name (e.g., the insured's health maintenance organization, or private supplementary insurance).

Please note: DSHS, Welfare, Provider Services, Healthy Kids, First Steps, Medicare, Indian Health, PCCM, Healthy Options, PCOP, etc., are inappropriate entries for this field.

10. **Is Patient's Condition Related To:** Required. Check *yes* or *no* to indicate whether employment, auto accident or other accident involvement applies to one or more of the services described in *field 24*. ***Indicate the name of the coverage source in field 10d*** (L&I, name of insurance company, etc.).

11. **Insured's Policy Group or FECA (Federal Employees Compensation Act) Number:** Primary insurance. When applicable. This information applies to the insured person listed in *field 4*. Enter the insured's policy and/or group number and his/her social security number. The data in this field will indicate that the client has other insurance coverage and Medicaid pays as payor of last resort.

11a. **Insured's Date of Birth:** Primary insurance. When applicable, enter the insured's birthdate, if different from *field 3*.

11b. **Employer's Name or School Name:** Primary insurance. When applicable, enter the insured's employer's name or school name.

11c. **Insurance Plan Name or Program Name:** Primary insurance. When applicable, show the insurance plan or program name to identify the primary insurance involved. *(Note: This may or may not be associated with a group plan.)*

11d. **Is There Another Health Benefit Plan?:** Required if the client has secondary insurance. Indicate *yes* or *no*. If yes, you should have completed *fields 9a.-d*. If the client has insurance, and even if you know the insurance will not cover the service you are billing, you must check *yes*. **If 11d. is left blank, the claim may be processed and denied in error.**

19. **Reserved For Local Use:** Required. When Medicare allows services, enter *XO* to indicate this is a crossover claim.

22. **Medicaid Resubmission:** When applicable. If this billing is being resubmitted more than six (6) months from Medicare's paid date, enter the Internal Control Number (ICN) that verifies that your claim was originally submitted within the time limit. (The ICN number is the *claim number* listed on the Remittance and Status Report.) Also enter the three-digit denial Explanation of Benefits (EOB).

24. **Enter only one (1) procedure code per detail line (fields 24A - 24K). If you need to bill more than six (6) lines per claim, please use an additional HCFA-1500 claim form.**

24A. **Date(s) of Service:** Required. Enter the "from" and "to" dates using all six digits for each date. Enter the month, day, and year of service numerically (e.g., October 4, 2003 = 100403). **Do not use slashes, dashes, or hyphens to separate month, day or year (MMDDYY).**

24B. **Place of Service:** Required. Enter a 11.

24C. **Type of Service:** No longer required.

24D. **Procedures, Services or Supplies CPT/HCPCS:** Required. **Coinsurance and Deductible:** Enter the total combined and deductible for each service in the space to the right of the modifier on each detail line.

24E. **Diagnosis Code:** Enter the ICD-9-CM diagnosis code related to the procedure or service being billed.

24F. **$ Charges:** Required. Enter the amount you billed Medicare for the service performed. If more than one unit is being billed, the charge shown must be for the total of the units billed. Do not include dollar signs or decimals in this field. Do not add sales tax.

24G. **Days or Units:** Required. Enter the total number of program units for each line. These figures must be whole units.

24K. **Reserved for Local Use:** Required. Use this field to show Medicare allowed charges. Enter the Medicare allowed charge on each detail line of the claim (see sample).

26. **Your Patient's Account No.:** Not required. Enter an alphanumeric ID number, for example, a medical record number or patient account number. This number will be printed on your Remittance and Status Report under the heading *Patient Account Number*.

27. **Accept Assignment**: Required. Check **yes**.

28. **Total Charge:** Required. Enter the sum of your charges. Do not use dollar signs or decimals in this field.

29. **Amount Paid:** Required. Enter the Medicare Deductible here. Enter the amount as shown on Medicare's Remittance Notice and Explanation of Benefits. If you have more than six (6) detail lines to submit, please use multiple HCFA-1500 claim forms (see field 24) and calculate the deductible based on the lines on each form. **Do not include coinsurance here**.

30. **Balance Due:** Required. Enter the Medicare Total Payment. Enter the amount as shown on Medicare's Remittance Notice or Explanation of Benefits. If you have more than six (6) detail lines to submit, please use multiple HCFA claim forms (see field 24) and calculate the Medicare payment based on the lines on each form. **Do not include coinsurance here**.

32. **Name and Address of Facility Where Services Are Rendered:** Required. Enter Medicare Statement Date *and* any Third-Party Liability Dollar Amount (e.g., auto, employee-sponsored, supplemental insurance) here, if any. If there is insurance payment on the claim, you must also attach the insurance Explanation of Benefits (EOB). **Do not include coinsurance here**.

33. **Physician's, Supplier's Billing Name, Address, Zip Code and Telephone Number:** Required. Put the *Name, Address,* and *Telephone Number* on all claim forms.

Group: Required. Please enter your seven-digit provider number assigned to you by MAA.

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

SAMPLE

APPROVED OMB-0938-0008

SAMPLE A: MEDICARE COINSURANCE AND SUPPLEMENTAL INSURANCE

PICA

HEALTH INSURANCE CLAIM FORM

PICA

CARRIER

1. MEDICARE ☐ (Medicare #) MEDICAID ☒ (Medicaid #) CHAMPUS ☐ (Sponsor's SSN) CHAMPVA ☐ (VA File #) GROUP HEALTH PLAN ☐ (SSN or ID) FECA BLK LUNG ☐ (SSN) OTHER ☐ (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): H-041915HANSON

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): HANSON HARRY

3. PATIENT'S BIRTH DATE MM DD YY: 04 19 31 SEX M ☐ F ☒

4. INSURED'S NAME (Last Name, First Name, Middle Initial):

5. PATIENT'S ADDRESS (No., Street): 16 STUMP ROAD

6. PATIENT RELATIONSHIP TO INSURED: Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street):

CITY: ANYTOWN STATE: WA

8. PATIENT STATUS: Single ☐ Married ☐ Other ☐

CITY: STATE:

ZIP CODE: 98000 TELEPHONE (Include Area Code): ( )

Employed ☐ Full-Time Student ☐ Part-Time Student ☐

ZIP CODE: TELEPHONE (INCLUDE AREA CODE): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER: 123 456 789

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES ☐ NO ☒

a. INSURED'S DATE OF BIRTH MM DD YY: SEX M ☐ F ☐

b. OTHER INSURED'S DATE OF BIRTH MM DD YY: SEX M ☐ F ☐

b. AUTO ACCIDENT? YES ☐ NO ☒ PLACE (State):

b. EMPLOYER'S NAME OR SCHOOL NAME:

c. EMPLOYER'S NAME OR SCHOOL NAME:

c. OTHER ACCIDENT? YES ☐ NO ☒

c. INSURANCE PLAN NAME OR PROGRAM NAME: AETNA - SUPPLEMENT

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES ☒ NO ☐ *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

PATIENT AND INSURED INFORMATION

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE: XO

20. OUTSIDE LAB? YES ☐ NO ☐ $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 343.9
2. ____.__
3. ____.__
4. ____.__

22. MEDICAID RESUBMISSION CODE: ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 10	01	03	10	01	03	11		97001	11.50	343.9	4482	1				37.48
2																
3																
4																
5																
6																

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER SSN ☐ EIN ☐

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES ☐ NO ☐

28. $ TOTAL CHARGE: 4482

29. $ AMOUNT PAID:

30. $ BALANCE DUE: 4482

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

11/16/03
$13.01

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

THERAPY INC
PO BOX 1111
ANYTOWN, WA 98000 360-555-0909

PIN# GRP# 7654321

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) ***PLEASE PRINT OR TYPE*** FORM HCFA-1500 (12-90), FORM RRB-1500, FORM OWCP-1500

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

SAMPLE

SAMPLE B: MEDICARE DEDUCTIBLE AND COINSURANCE

APPROVED OMB-0938-0008

PICA

HEALTH INSURANCE CLAIM FORM

PICA

CARRIER

1. MEDICARE [ ] (Medicare #) MEDICAID [X] (Medicaid #) CHAMPUS [ ] (Sponsor's SSN) CHAMPVA [ ] (VA File #) GROUP HEALTH PLAN [ ] (SSN or ID) FECA BLK LUNG [ ] (SSN) OTHER [ ] (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): R-111231BROWNB

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): BROWN ROBERT

3. PATIENT'S BIRTH DATE MM DD YY: 11 12 31 SEX M [ ] F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial):

5. PATIENT'S ADDRESS (No., Street): 23 MAINE

6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street):

CITY: ANYTOWN STATE: WA

8. PATIENT STATUS: Single [ ] Married [ ] Other [ ] Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

CITY: STATE:

ZIP CODE: 98000 TELEPHONE (Include Area Code): ( )

ZIP CODE: TELEPHONE (INCLUDE AREA CODE): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER:

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES [ ] NO [X]

a. INSURED'S DATE OF BIRTH MM DD YY: SEX M [ ] F [ ]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY: SEX M [ ] F [ ]

b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State):

b. EMPLOYER'S NAME OR SCHOOL NAME:

c. EMPLOYER'S NAME OR SCHOOL NAME:

c. OTHER ACCIDENT? YES [ ] NO [X]

c. INSURANCE PLAN NAME OR PROGRAM NAME:

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [X] *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

PATIENT AND INSURED INFORMATION

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE: XO

20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 343.9
2. ____.__
3. ____.__
4. ____.__

22. MEDICAID RESUBMISSION CODE: ORIGINAL REF. NO.:

23. PRIOR AUTHORIZATION NUMBER:

24. A DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1	10	01	03	10	01	03	11		97504	5.50	343.9	3458	2				27.46
2																	
3																	
4																	
5																	
6																	

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER SSN [ ] EIN [ ]

26. PATIENT'S ACCOUNT NO.: 21200

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [ ] NO [ ]

28. $ TOTAL CHARGE: 3458

29. $ AMOUNT PAID:

30. $ BALANCE DUE: 3458

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

11/16/03
$13.01

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

OCCUPATIONAL THERAPY USA
123 MAIN ST
ANYTOWN, WA 98000 360-555-4444

PIN# GRP# 7654321

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) ***PLEASE PRINT OR TYPE*** FORM HCFA-1500 (12-90), FORM RRB-1500, FORM OWCP-1500